



1384 S. Fifth Street
St. Charles, MO 63301
(636) 946-9242
fax: (636) 946-4903

13025 Olive Street Road
Creve Coeur, MO 63141
(314) 878-8770
fax: (314) 878-5971

1325 G Queens Court
St. Peters, MO 63376
(636) 441-8010
fax: (636) 441-5128

532 Old Smizer Mill Road
Fenton, MO 63026
(636) 305-7110
fax: (636) 305-9509

1155 Wentzville Parkway, Suite 119
Wentzville, MO 63385
(636) 639-9422
fax: (636) 639-6713

Last Name: _____ First Name: _____ MI: _____ Date: _____

Address: _____

Cell Phone Number: (____) _____ Work Phone Number: (____) _____

Email: _____

Changes Medical History: _____

Current Meds: _____

Height: _____ Weight: _____

Allergies to Meds: Yes/No Which: _____ Reactions: _____

Primary Care Physician: _____ Location: _____ Phone: _____

Preferred Pharmacy: _____ Location: _____ Phone: _____

Race/Ethnicity:

- Unknown African American American Indian Arab Asian Hispanic or Latino Not Hispanic or Latino Gender: Male or Female
 Caucasian Hawaiian Hispanic Latino Indian Multiracial Dominant Hand: R or L

Preferred Language: _____

Smoking:

- Current Every Day Smoker
 Current Some Day Smoker
 Former Smoker
 Never Smoker
 Smoker (Current Status Unknown)

Do Either Apply:

Pregnant Yes No N/A
Nursing Yes No N/A

**ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES**

The law requires that Midwest Eye Associates, Inc. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- I have read or had explained to me Midwest Eye Associates, Inc. Notice of Privacy Practices and agree to continue my care with Midwest Eye Associates, Inc. under said terms.
- I was given the opportunity to read Midwest Eye Associates, Inc. Notice of Privacy Practices and declined but wish to continue my care with Midwest Eye Associates, Inc. under the terms of Midwest Eye Associates, Inc. privacy policies.
- I have read or had explained to me Midwest Eye Associates, Inc. Notice of Privacy Practices and do not wish to continue my care with Midwest Eye Associates, Inc. under said terms.
- The Notice of Privacy Practices could not be read due to the emergent nature of the care or other reason described as

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient

Date

If you are signing as a personal representative of the patient, please indicate your relationship:

Representative

Relationship to Patient

PATIENT FINANCIAL RESPONSIBILITY

I authorize **Midwest Eye Associates, Inc., Drs. Bradley A. Byergo, Jerome L. Becker, Bradley E. Borello, and Seth M. Bachelier**, to apply for benefits on my behalf for any services performed by them. I agree to assign my benefits and request that all payments from my insurance plan(s) be made directly to the above provider(s). I agree to assume responsibility of any unpaid balances not covered by my insurance plan(s), or to assume full responsibility for patient fees if I have no insurance coverage.

Patient Signature: _____

If patient is a minor, parent or guardian is required to sign above.

Responsible Party Signature (if different from above): _____